

PAY BY VISA, MASTERCARD OR DISCOVER. PAID OUT BELOW:		
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD
Please note that we assess a convenience fee of \$5.00 per transaction.		

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████3937	\$11.16



107100-242

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████3921
Amount: \$11.15
Interest Due: \$0.01
Total Balance Due: \$11.16

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice, this office will obtain verification of the debt or obtain a copy of a judgment and mail you a copy of such judgment or verification. Upon written request made within 30 days of receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

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Make payment online at: www.medcah.com

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Mailing address:
P.O. Box 1187
Kailua, HI 96734
808-266-2020 or
Toll Free 1-888-663-3224

Oahu Office:
320 Uluniu Street, Suite 5
Kailua, HI 96734
808-266-2020 or
Toll Free 1-888-663-3224

Hilo Office:
180 Kinoole Street, Suite 205
Hilo, HI 96720
808-935-4535 or
Toll Free 1-800-935-4540

Filed 07/05/17 Page 2 of 17 PageID #: 361

PAYMENT BY VISA, MASTERCARD OR DISCOVER. Fill out below.

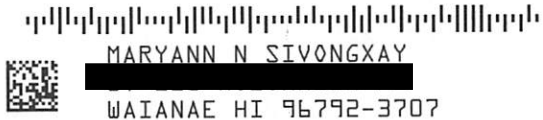
☐ VISA ☐ MASTERCARD ☐ DISCOVER

CARD NUMBER EXP. DATE AMOUNT

SIGNATURE MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD

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Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████3938	\$21.18



107100 - 243

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187

** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████6101
Amount: \$21.16
Interest Due: \$0.02
Total Balance Due: \$21.18

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD
Please note that we assess a convenience fee of \$5.00 per transaction.		

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████3939	\$5.53



107100 - 244

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████0780
Amount: \$5.52
Interest Due: \$0.01
Total Balance Due: \$5.53

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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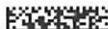
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<input type="checkbox"/> VISA  <input type="checkbox"/> MASTERCARD  <input type="checkbox"/> DISCOVER 		
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD
Please note that we assess a convenience fee of \$5.00 per transaction.		

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████3940	\$3.25



107100-245

MARYANN N SIVONGXAY

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MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: █████0802
Amount: \$3.25
Interest Due: \$0.00
Total Balance Due: \$3.25

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<input type="checkbox"/> VISA 			<input type="checkbox"/> MASTERCARD 			<input type="checkbox"/> DISCOVER 		
CARD NUMBER			EXP. DATE			AMOUNT		
SIGNATURE						MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD		
Please note that we assess a convenience fee of \$5.00 per transaction.								

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████3941	\$2.48



107100 - 246

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.

P.O. Box 1187

Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: █████1771
Amount: \$2.48
Interest Due: \$0.00
Total Balance Due: \$2.48

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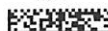
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Filed 07/05/17 Page 6 of 17 PageID #: 365

<input type="checkbox"/> VISA  <input type="checkbox"/> MASTERCARD  <input type="checkbox"/> DISCOVER 		
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD

Please note that we assess a convenience fee of \$5.00 per transaction.

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████ 8942	\$13.31

000247

107100 - 247

MARYANN N SIVONGXAY
████████████████████
WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187

107100-247

** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████ 0146
Amount: \$13.30
Interest Due: \$0.01
Total Balance Due: \$13.31

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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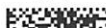
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CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD

Please note that we assess a convenience fee of \$5.00 per transaction.

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████3943	\$8.48



107100 - 248

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████6295
Amount: \$8.47
Interest Due: \$0.01
Total Balance Due: \$8.48

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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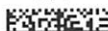
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<input type="checkbox"/> VISA  <input type="checkbox"/> MASTERCARD  <input type="checkbox"/> DISCOVER 		
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SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD
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Date	MEDCAH Acct #	Total Due
April 27, 2015	████████3944	\$5.17



107100 - 249

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████6318
Amount: \$5.16
Interest Due: \$0.01
Total Balance Due: \$5.17

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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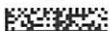
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CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD
Please note that we assess a convenience fee of \$5.00 per transaction.		

Date	MEDCAH Acct #	Total Due
April 27, 2015	████████3945	\$3.03



107100 - 250



MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.

P.O. Box 1187

Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████6325
Amount: \$3.03
Interest Due: \$0.00
Total Balance Due: \$3.03

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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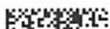
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Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████3946	\$12.20



107100 - 251

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

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P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████3043
Amount: \$12.19
Interest Due: \$0.01
Total Balance Due: \$12.20

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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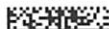
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808-935-4535 or
Toll Free 1-800-935-4540



7 MONTHS BY VISA, MASTERCARD OR DISCOVER. Fill out below.

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD

Please note that we assess a convenience fee of \$5.00 per transaction.

Date	MEDCAH Acct #	Total Due
April 27, 2015	████████3947	\$13.31



107100 - 252



MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████1286
Amount: \$13.30
Interest Due: \$0.01
Total Balance Due: \$13.31

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice, this office will obtain verification of the debt or obtain a copy of a judgment and mail you a copy of such judgment or verification. Upon written request made within 30 days of receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

Interest may be added to the outstanding principal balance as allowed by your agreement with your creditor and/or as allowed by law. Please be advised that a service fee of \$30.00 will be assessed for any check or electronic payment returned from the bank unpaid.

As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the term of your credit obligation. But we will not submit a negative credit report to a credit reporting agency about this credit obligation until the expiration of the time period described above.

Make payment online at: www.medcah.com

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This communication is from a debt collection company. This is an attempt to collect a debt, and any information obtained will be used for that purpose.



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808-266-2020 or
Toll Free 1-888-663-3224

Oahu Office:
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Kailua, HI 96734
808-266-2020 or
Toll Free 1-888-663-3224

Hilo Office:
180 Kinoole Street, Suite 205
Hilo, HI 96720
808-935-4535 or
Toll Free 1-800-935-4540



FILED 07/05/17 Page 12 of 17 PageID #

PAY BY VISA, MASTERCARD OR DISCOVER. Fill out below.		
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD
Please note that we assess a convenience fee of \$5.00 per transaction.		

Date	MEDCAH Acct #	Total Due
April 27, 2015	████████3948	\$13.95



107100 - 253

MARYANN N STVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████5693
Amount: \$13.93
Interest Due: \$0.02
Total Balance Due: \$13.95

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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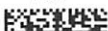
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808-935-4535 or
Toll Free 1-800-935-4540



Filed 07/05/17 Page 13 of 17 PageID #: 710517

Please detach and return this portion with your payment.		
<input type="checkbox"/> VISA  <input type="checkbox"/> MASTERCARD  <input type="checkbox"/> DISCOVER 		
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD
Please note that we assess a convenience fee of \$5.00 per transaction.		

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████ 3949	\$8.74



107100 - 254

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.

P.O. Box 1187

Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████ 7445
Amount: \$8.73
Interest Due: \$0.01
Total Balance Due: \$8.74

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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Toll Free 1-888-663-3224

Oahu Office:

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Kailua, HI 96734

808-266-2020 or

Toll Free 1-888-663-3224

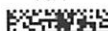
Hilo Office:

180 Kionoole Street, Suite 205

Hilo, HI 96720

808-935-4535 or

Toll Free 1-800-935-4540



7. PAY BY VISA, MASTERCARD OR DISCOVER. Fill out below.

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD

Please note that we assess a convenience fee of \$5.00 per transaction.

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████3950	\$5.65

107100 - 255
MARYANN N SIVONGXAY
████████████████████
WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187
██

** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████9006
Amount: \$5.64
Interest Due: \$0.01
Total Balance Due: \$5.65

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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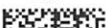


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808-935-4535 or
Toll Free 1-800-935-4540

EXHIBIT ONE



7 MONTH VISA/MASTERCARD OR DISCOVER, PAY OUT BELOW

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD

Please note that we assess a convenience fee of \$5.00 per transaction.

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████3951	\$13.31



107100 - 256

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████5832
Amount: \$13.30
Interest Due: \$0.01
Total Balance Due: \$13.31

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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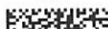
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Filed 07/05/17 Page 16 of 17 PageID #: 170517

<input type="checkbox"/> VISA 		<input type="checkbox"/> MASTERCARD 	<input type="checkbox"/> DISCOVER 
CARD NUMBER	EXP. DATE	AMOUNT	
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

Please note that we assess a convenience fee of \$5.00 per transaction.

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████ 8952	\$9.00



107100 - 257

MARYANN N SIVONGXAY

WAIANAE HI 96792-3707

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████ 2469
Amount: \$8.99
Interest Due: \$0.01
Total Balance Due: \$9.00

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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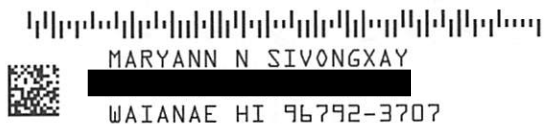
EXHIBIT ONE

7 MONTH VISA/MASTERCARD OR DISCOVER, Fill Out Below

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD

Please note that we assess a convenience fee of \$5.00 per transaction.

Date	MEDCAH Acct #	Total Due
April 27, 2015	██████████ 3953	\$7.94



107100 - 258

MEDCAH, Inc.
P.O. Box 1187
Kailua, HI 96734-1187



** Please Detach the Top Portion and Return with Payment **

COLLECTION NOTICE

Creditor: WAIANAE COAST COMP HEALTH CTR
Creditor Account #: ██████████ 2477
Amount: \$7.93
Interest Due: \$0.01
Total Balance Due: \$7.94

This account has been listed with our office for collection. If paid in full to this office all collection activity will be stopped. To establish a payment plan, please call our office at (808) 266-2020.

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EXHIBIT ONE

